



STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING
BOARD OF CHIROPRACTIC EXAMINERS
P.O. BOX 110806
JUNEAU, ALASKA 99811-0806
(907) 465-2543 ★ Fax: (907) 465-2974
E-mail: license@commerce.state.ak.us
Website: www.commerce.state.ak.us/occ/pchi.htm

CHIROPRACTIC COURTESY LICENSE APPLICATION

In accordance with AS 08.20.100(a), a person may not practice chiropractic or use chiropractic core methodology in the State of Alaska without a license.

NOTE: Please read the application, statutes, regulations, and all instructions carefully. It is your responsibility to be aware of licensing requirements and provide all necessary documentation. No license will be issued until your application file is complete and the board approves your application for a courtesy license.

A courtesy license will be issued to nonresident and nonresident aliens only.

A courtesy license authorizes the licensee to practice chiropractic for a special event only. A courtesy license does not authorize the licensee to conduct a general chiropractic practice or to perform services outside the scope of practice required for that special event.

Services are limited to persons involved with the special event, such as athletes, members, coaches or staff of the event. A courtesy license is valid for seven days prior, during, and post the event.

The following must be submitted no later than **45 days before** the special event for which the courtesy license is requested:

1. Check or money order payable to the State of Alaska as follows:
 - \$ 50.00 Application Fee (Nonrefundable)
 - \$100.00 Courtesy License Fee
2. Complete notarized or postmaster stamped application with photograph.
3. Verification of a valid license in another state, jurisdiction or foreign country sent directly to the Division of Occupational Licensing from the licensing authority.
4. Complete "Authorization and Release of Records" form.

The Division of Occupational Licensing will contact the Federation of Chiropractic Licensing Boards to perform a check of the national licensee database to verify any action(s) that may have been reported regarding the applicant.

GENERAL INFORMATION

SOCIAL SECURITY NUMBERS

Alaska Statute 08.01.060(b) requires an applicant for a professional license to provide a United States Social Security Number. Applicants who do not have a Social Security Number must complete the "Request for Exception from Social Security Number Requirement" (Form 08-4372) located on the division's website at: www.commerce.state.ak.us/occ.

ABANDONMENT

Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice and the application fee is forfeited.

Please be aware that all information on this form will be available to the public, unless required to be kept confidential by state or federal law. In addition, current licensee information is available on the division's website at: www.commerce.state.ak.us/occ under "Professional License Search."

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THIS APPLICATION MUST BE COMPLETED IN FULL. TYPE OR PRINT ALL INFORMATION IN INK.

If any section does not apply, please write N/A in the space provided.

Submit a complete "notarized or postmaster stamped" application form and all supporting documents to the address above.

 Submit \$50.00 Application Fee (Nonrefundable)

☐ Submit \$100.00 Courtesy License Fee

Fees are to be paid in the form of a check or money order, payable to the State of Alaska.

I HEREBY MAKE APPLICATION for a courtesy license as a Chiropractic Physician in the State of Alaska.

Full Name _____ Social Security Number _____
 Last First Initial

Address _____
 Street or P.O. Box _____ City _____ State _____ Zip Code _____

Work Telephone _____ Home Telephone _____ ☐ Resident ☐ Nonresident

Date of Birth: Sex:

Citizen of the United States ☐ Yes ☐ No

Have you ever been known by any other name? ☐ Yes ☐ No _____
(If name change was by court order, enclose a copy of such order.)

Dates of Special Event: _____

Description of Special Event:

The scope of practice required for the event:

CHARACTER REFERENCES

List six character references, three of which are professional references.

| | FULL NAME | COMPLETE ADDRESS AND ZIP CODE | RELATIONSHIP |
|----|-----------|-------------------------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

CHIROPRACTIC HISTORY

PRACTICE

Include temporary or part-time work. State as to each employment or period of practice, the period during which you were employed as a chiropractor (or engaged in private practice) including dates, the address of the offices or places where you were so employed or engaged, and the names and addresses of all employers, partners, associates, or places where you practiced chiropractic, if any, and the reason for the termination of each employment or period of private practice.

| INCLUSIVE DATES | | ADDRESS, NAMES OF EMPLOYERS, ASSOCIATES, ETC. | STATUS, I.E., PART-TIME | REASON FOR LEAVING |
|-----------------|-------|--|----------------------------|--------------------|
| Began | Ended | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you presently engaged in the clinical practice of chiropractic? ☐ Yes ☐ No If "yes," give location below:

Number of years at location below: _____

Location of Clinical Chiropractic Practice: _____
Street City, State, Zip Code (Country)

OTHER STATE LICENSES

To qualify for a courtesy license, the applicant must have held a license in good standing to practice chiropractic in another jurisdiction for the five years preceding the date of application.

List all licenses for the practice of chiropractic that you now hold or ever have held:

| JURISDICTION | LICENSED BY: (Exams, Reciprocal, or other) | LICENSE NO. | DATE OF ISSUANCE | EXPIRATION DATE |
|--------------|---|-------------|------------------|-----------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

DISCIPLINARY / INVESTIGATION / PRACTICE QUESTIONS

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you have criminal charges pending against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are there any unsatisfied judgments against you resulting from the practice of chiropractic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any investigations against you, in any state, jurisdiction, or foreign country? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever:

- | | | |
|---|--------------------------|--------------------------|
| 4. practiced chiropractic illegally? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. secured or attempted to secure a license through deceit, fraud, or intentional misrepresentation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. advertised professional services in a false or misleading manner? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. been convicted, including a conviction based on a guilty plea or plea of nolo contendere, of a felony or misdemeanor (other than a minor traffic violation)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. been convicted, including a conviction based on a guilty plea or plea of nolo contendere, of a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. intentionally or negligently engaged in or permitted the performance of patient care by persons under your supervision that does not conform to minimum professional standards (regardless of whether actual injury to the patient occurred)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. failed to comply with a board order? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. continued or attempted to practice after becoming unfit due to professional incompetence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. engaged in lewd or immoral conduct in connection with the delivery of professional services to patients? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. failed to satisfy board-adopted continuing education requirements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. had any malpractice settlements or judgments paid on your behalf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. had your chiropractic license denied, revoked, suspended, surrendered, placed on probation, recalled, cancelled, or been the subject of any restriction, censure, reprimanded, or other disciplinary action in any jurisdiction or foreign country? | <input type="checkbox"/> | <input type="checkbox"/> |

PERSONAL HISTORY QUESTIONS:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 17. Are you now, or within the last five years have you been addicted to, or have you undergone treatment for the use of narcotics or drugs or excessive use of intoxicating liquors? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you now experiencing, or have you within the last five years experienced a physical or mental disability? | <input type="checkbox"/> | <input type="checkbox"/> |

Within in the last five years have you:

- | | | |
|--|--------------------------|--------------------------|
| 19. been adjudicated an incompetent or an insane person by any court? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. been a patient in any sanitarium, hospital, or mental institution for mental illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. continued or attempted to practice after becoming unfit due to addiction or severe dependency on alcohol or a drug that impairs your ability to practice safely? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. continued or attempted to practice after becoming unfit due to physical or mental disability? | <input type="checkbox"/> | <input type="checkbox"/> |

A "Yes" answer may not prejudice your application, failure to report honestly may.

If you answered "Yes" to any of the above questions (1 – 22), please explain dates, locations and circumstances on a separate piece of paper. Also, submit any/all supporting documents that are applicable (court records, board actions, investigation notices etc.).

If you answered "yes" to questions 17 – 22 you must also submit a statement from your health care provider indicating your ability to practice the chiropractic profession.

_____, being first duly sworn upon his/her oath, deposes and says:
(Applicant Name)

I make the following voluntary statement and no threats, promises, or any form of duress have been used to induce me to make this statement.

By my signature below, I declare that all facts, statements, and answers contained in this application are true and correct; I am not omitting any information that might be of value to this board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar issuance of a license to me by the state board and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Alaska Chiropractic Courtesy License even though it is not discovered until after issuance.

I give permission to the Alaska Board of Chiropractic Examiners to secure additional information concerning me or any statement in this application from any person or any source the board may desire. I further agree to submit to questioning by the board or any member thereof, and to substantiate any statements if desired by the board.

I solemnly declare upon my honor that if granted a license to practice chiropractic in Alaska, I will respectfully comply with any law governing the practice of chiropractic in this state, and will do my best to uphold and maintain the ethics of the profession.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

WARNING: Pursuant to AS 08.20.170, the board may refuse to issue a license to, or impose a disciplinary sanction on, a person who has obtained or attempted to obtain a license to practice as a chiropractor by fraud, deceit or intentional misrepresentation. The person may also be subject to criminal charges for perjury (AS 11.56.200).

I certify that the above information is true and correct.

Applicant Signature

Date

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of _____ this _____ day
of _____, 20_____.

Applicant photograph

Applicant to sign across photograph.

Notary Public Signature

My Commission Expires: _____

NOTARY SEAL
or
(postmaster stamp if notary public is not available)

**ALASKA STATE BOARD OF CHIROPRACTIC EXAMINERS
AUTHORIZATION FOR INTERSTATE EXCHANGE OF EXAMINATION
AND LICENSURE INFORMATION**

This form is essential to the application you are filing with this board. Before your application can be considered for approval, the information requested below must be officially verified by the chiropractic board(s) in **all** states or foreign countries where you hold or have ever held a license. Please complete the information requested and forward it to the state(s) or foreign country(ies) in which you hold or have ever held a license to practice. You are advised to check with that state or foreign country before forwarding this form to determine if there are additional requirements to be met before the information will be released, i.e., verification fee.

PART I

TO BE COMPLETED BY THE APPLICANT (Please type or print legibly):

| | | | |
|--|------------|--------------------|-------------|
| <hr/> | <hr/> | <hr/> | <hr/> |
| Last Name | First Name | Middle Name | Maiden Name |
| <hr/> | | | |
| Mailing Address | | | |
| <hr/> | | | |
| City | State | Zip Code | |
| <hr/> | | | |
| Date of Birth: <hr/> | | License No.: <hr/> | |
| <p>I hereby request and authorize <hr/> to provide any and all pertinent information requested in this form to the Alaska Board of Chiropractic Examiners to complete an application filed with that agency.</p> | | | |
| <hr/> | | <hr/> | |
| Signature | | Date Signed | |

PART II – NOT TO BE COMPLETED BY THE APPLICANT

The above applicant is applying for licensure in this state. Please complete the following and **return directly to the Alaska State Board of Chiropractic Examiners.**

State/Agency

Name of Licensee

Graduate of

License No.

 Issued Effective

By reciprocity/endorsement

 By examination

License is current

 lapsed

 Expiration date

If the applicant's license has lapsed or expired, please explain why (e.g., failure to pay licensing renewal fees, etc.):

Date of exam

 The examination consisted of the following subjects:

| | | | | |
|-----------|------------------------------------|------------------------------|-----------------------------|-------------|
| Written: | Principles and Practice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Score <hr/> |
| Clinical: | Adjustive Technique | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Score <hr/> |
| | Ortho-Neuro | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Score <hr/> |
| | Physiotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Score <hr/> |
| | X-ray Interpretation and Technique | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Score <hr/> |

OTHER SUBJECT AREAS TESTED

| SUBJECTS | GRADES | PRACTICAL/ORAL/WRITTEN |
|----------|--------|------------------------|
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |

Has the applicant's license ever been suspended or revoked? ☐ Yes ☐ No If "yes", for what reason?

Has the applicant been subject to any other disciplinary action(s) (e.g., letter of warning, stipulation)? ☐ Yes ☐ No
If "yes", please provide a copy of the official action taken.

Please provide any information you believe relevant to the applicant's qualifications and fitness to practice chiropractic.

General Comments: _____

STATE BOARD
OR
AGENCY
SEAL

Signed: _____

Printed Name: _____

Title: _____

State/Agency: _____

Date: _____

Please return this form directly to:

Department of Commerce, Community, and
Economic Development
Division of Occupational Licensing
Alaska Board of Chiropractic Examiners
P.O. Box 110806
Juneau, AK 99811-0806

THIS FORM MUST BE COMPLETED AND RETURNED WITH THE APPLICATION

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Occupational Licensing
Board of Chiropractic Examiners
P.O. Box 110806
Juneau, Alaska 99811-0806
(907) 465-2543
E-mail: license@commerce.state.ak.us
Website: www.commerce.state.ak.us/occ/pchi.htm

AUTHORIZATION AND RELEASE

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)

_____, hereby authorize the
(Please print full address)

Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my practice of chiropractic, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice chiropractic.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law.

I request that upon presentation of this release, or a certified true copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

Signature of Applicant

Date

Home Telephone Number

Work Telephone Number

SUBSCRIBED AND SWORN to before me, a Notary Public, in and for the State of _____

this _____ day of _____, 20_____.

NOTARY SEAL
OR
(postmaster stamp if notary
not available)

Notary Public Signature

My Commissioner Expires: _____

NOTE: A photocopy reproduction of this request shall be, for all intents and purposes, as valid as the original.